CLINICAL EDIT CRITERIA PROPOSAL

Drug/Drug Class: **ACE Inhibitors**

Prepared by: Missouri Medicaid

☒ **New Criteria** ☐ **Revision of Existing Criteria**

Executive Summary

Purpose: To reduce drug costs by limiting prescribing to preferred ACE inhibitor(s).

Why Was This Issue Selected: For the previous reporting period (July 2001 - June 2002) the Missouri Medicaid Pharmacy Program paid $14,601,905 for angiotensin converting enzyme inhibitors. This represents 1.87% of the total drug spend.

Program-Specific Information:

Reference Drug/Drugs With No Clinical Edit Imposed:

Trade Name	Generic Name
	LISINOPRIL
	CAPTOPRIL
	CAPTOPRIL/HCTZ

Total Scripts in Drug Class	Projected Savings in Drug Class
438,300	$3.1 Million

Drugs Which Will Be Affected By Clinical Edits:

Trade Name	Generic Name
LOTENSIN	BENAZEPRIL
LOTENSIN/HCL	BENAZEPRIL/HCTZ
VASOTEC	ENALAPRIL
VASERETIC	ENALAPRIL/HCTZ
MONOPRIL	FOSINOPRIL
MONOPRIL HCTZ	FOSINOPRIL/HCTZ
UNIVASC	MOEXIPRIL
UNIRETIC	MOEXIPRIL/HCTZ
ACEON	PERINDOPRIL
ACCUPRIL	QUINAPRIL
ACCURETIC	QUINAPRIL/HCTZ
ALTACE	RAMIPRIL
MAVIK	TRANDOLAPRIL

Setting & Population: All patients taking ACE inhibitors other than reference drug(s).

Type of Criteria: ☐ Increased Risk of ADE ☒ Non-Preferred Agent
☐ Appropriate Indications

Purpose of Clinical Edit Criteria

While prescription expenditures are increasing at double-digit rates, payors are also evaluating ways to control these costs by influencing prescriber behavior and guide appropriate medication usage. Clinical Edit criteria assist in the achievement of qualitative and economic goals related to health care resource utilization. Restricting the use of certain medications can reduce costs by requiring documentation of appropriate indications for use, and where appropriate, encourage the use of less expensive agents within a drug class. Clinical Edit criteria can also reduce the risk of adverse events associated with medications by identifying patients at increased risk due to diseases or medical conditions, or those in need of dosing modifications.

Why Has This Issue Been Selected For Review?

Hypertension is defined as systolic blood pressure (SBP) of 140 mmHg or greater, diastolic blood pressure (DBP) of 90 mmHg or greater, or taking antihypertensive medication.[1] The objective of identifying and treating high blood pressure is to reduce the risk of cardiovascular disease and associated morbidity and mortality.[1] ACE inhibitors are considered first line therapy in hypertension. These drugs are effective alone or in combination, usually with thiazide-type diuretics. They have been shown to provide beneficial effects in a variety of hypertension-related processes, including heart failure from systolic dysfunction and neuropathy. ACE inhibitors are preferred because of fewer adverse effects on glucose homeostasis, lipid profiles, and renal function.[1] In patients with diabetic neuropathy, ACE inhibitors are preferred. These drugs are shown to be clinically significant in treating patients with hypertension and co-existing cardiovascular diseases. ACE inhibitors are proven useful after myocardial infarction, especially with left ventricular systolic dysfunction to prevent subsequent heart failure and mortality.[1]

Of the ACE inhibitors, lisinopril is the most cost effective agent for use in the Missouri Medicaid Pharmacy Program. Its side effect profile, as well as available medical and clinical information, exceeds or is comparable to other drug choices within the same therapeutic class. This product is a reference drug in national guideline approved therapy, and is consistent with consumer and medical recommendation sources.

Override Approval Criteria

- drug class for review: Angiotension Converting Enzyme (ACE) Inhibitors
- documented lisinopril treatment failure
- documented ADE to lisinopril

Override Denial Criteria

- no initial trial on reference drug(s)
- lack of adequate compliance during trial period

Required Documentation

- MedWatch Form
- Progress Notes

References

1. National Institute of Health 6th Report. High Blood Pressure. Joint National Committee. Nov. 1997.
2. Facts and Comparisons, 2002.
3. Micromedex Online. Http://healthcare.micromedex.com/mdx
4. USPDI, Micromedex, 2002